Peru 2000: Compliance with Ministry of Health Norms

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FINAL REPORT

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SUMMARY

This study evaluated compliance with family planning guidelines of the Peru Ministry of Health (MOH). Providers and clients were interviewed and/or observed in all the hospitals and main urban health centers and rural health posts within 12 health directorates (June 2000 - January 2001). A conceptual framework is offered to reconcile contradictory findings, formulate coherent recommendations, and guide future evaluations.

Voluntarism. Giving an informed choice of methods to clients was found to be a dominant provider value. Yet at one hospital six sterilized patients (of 248 interviewed at 32 hospitals during a 1-month study period) reported that they had been threatened (3) or offered incentives to accept sterilization (5). Spontaneous comments volunteered later by individual providers suggest that the pressures on clients reflected pressures from above to meet numerical family planning targets. Provisions of the U. S. Tiahrt Amendment were violated systemically at the health network headed by that hospital. The MOH reacted conducting a corrective workshop for its providers (n = 24) and airing a radio campaign on reproductive rights for the surrounding communities. At other hospitals, sterilization against clients' wishes was implied in three postpartum cases of women with reproductive risk. To prevent dogmatic public-health practices in the postpartum, pre-natal counseling must stress voluntarism and cesareans must be monitored nationwide. In rural health posts, three cases of incentives/threats were reported (out of n = 242 clients).

Comprehensible Information. According to simulated clients' observations at health centers (n = 118), providers displayed a sustained effort to assist clients in method choice. Yet, they spent considerable time in the initial phases of counseling (diagnosing client needs, offering method options) and focused too little on the method chosen by the client. Providers were generally more exhaustive instructing clients on method use than screening them for contraindications or alerting them about side effects. Observations of counseling sessions with real clients (n = 141) confirmed these trends. Presently, the MOH is using operations research to evaluate a service strategy that stresses balance and makes intensive use of job aids for providers and detailed written information for clients.

Numerical Targets. Number of couples protected was found to be a production target for 32 percent of hospital providers, 81percent of center providers, and 65 percent of post providers (out of n = 363). Over one-third of the providers said that they sought to attain quotas for specific contraceptives. Where perceived targets were present, the spontaneous response "Being fired" was given as an expected consequence of failure to meet the target by 4 percent of the tenured providers and 21 percent of the providers with short-term contracts ($p < .001$). Yet the more negative the expected consequences, the better was the providers' quality of care ($r = -.63$, $p < .01$). This can be explained by the fact that targets percolate from a set of valuable public health goals through which the system responds to abstract needs of the population. In preparation to attain the goal of reducing unmet need for contraception, the MOH sets programming targets that in practice become production targets for most providers. Public health and client rights may be well served if the MOH completes the transition to a client-oriented paradigm by making its goal-setting process, including target-setting, conform to the explicit goals of the MOH rather than to the goal of reducing the unmet need for contraception.

CONTENTS

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BACKGROUND

This report presents results of a study conducted by the Population Council to meet the information needs of the Peru Ministry of Health and USAID/Peru. The MOH needs periodic evaluation data to assess the extent to which its family planning providers comply with the National Family Planning Program's quality of care guidelines. USAID needs the information to determine whether the Tiahrt Amendment's Requirements for Voluntary Family Planning Projects are being met by projects using USAID funds. The study encompassed a national sample of providers and clients of MOH hospitals, urban health centers, and rural health posts. Data collection took place at 12 randomly sampled Health Directorates (DISAs) from June 2000 through January 2001.

STATEMENT OF THE PROBLEM

In 1997, human rights groups, religious activists and feminists severely criticized providers in the Peru Ministry of Health for coercing clients to accept long-acting methods, such as sterilization, and in early1998 the MOH introduced a number of changes in its programmatic goals and service guidelines. These focused primarily on the management of sterilization cases.

In mid-1999 the Population Council monitored providers' compliance with the new quality of care guidelines by means of simulated clients' observations of the provider-client interaction at hospitals and urban health centers, home follow-up interviews with clients sterilized at hospitals and family planning clients serviced at rural health posts; and exit interviews with family planning users at urban health centers. It was

found that providers treated clients with respect and generally ensured privacy during client-provider consultations. They informed clients about a variety of contraceptive methods and did not betray systematic biases in favor or against particular methods. On the other hand, some shortcomings were revealed insofar as screening for contraindications and providing information to clients were concerned. In handling VSC cases at hospitals, a majority of providers failed to comply with MOH standards concerning use of the *VSC Request Form* and the 72-hour reflection period between last counseling and surgical intervention (León, 1999*a*). The interviews with clients revealed that they knew a few generalities about family planning methods; yet specific knowledge pertaining to the method currently used was limited and clients knew more about its usage instructions and follow-up than about its side effects (León, 1999*b*).

Considering these results, the MOH stepped up on-going corrective actions and issued and distributed to providers a comprehensive set of *Norms of the National Family Planning Program* (MOH, 1999) previously consulted with local counterparts, including the national civil rights Ombudsman; established new evaluation and supervision systems; and furthered provider training.

A second-round evaluation was needed in year 2000. The research strategy needed adjustments to address some methodological problems observed in the 1999 monitoring study.

- **Sampling Strategy.** The sampling strategy of the Population Council's 1999 evaluation was far from perfect. The hospital sample was not evenly distributed in Peru's territory and the sampling procedure diminished the likelihood that hospitals with lower sterilization case loads were included in the sample.

- **Quality of Care Standards.** Another limitation was that the purpose of the 1999 study was to monitor the major trends in providers' compliance with the family planning norms and identify the major areas needing improvements. The Lot Quality Assessment Sampling methodology used in the evaluation failed to take into account finer nuances. A sharpened focus on individual deviations is needed when the reproductive rights of clients are at stake.

- **Loss of Subjects and Recall Problems.** In 1999 the names of recently sterilized patients were obtained from hospitals' administrative records and home visits were performed to obtain clients' retrospective quality of care accounts. Many addresses could not be found and the need arose to recur to replacements, yielding a final sample that may have not been strictly representative of the patient population. Moreover, persons sterilized six to 12 months back were interviewed and memory problems probably reduced the accuracy of their retrospections.

- **Services in Rural Posts.** Loss of cases and memory problems also afflicted the follow-up of women who had received family planning services at rural health posts. The study's exclusive focus on cases of completed family planning services may have represented an additional bias. Women who could have rejected family planning in the context of maternal-child health services were not considered.

- **Provider Responses.** The 1999 *Norms* explicitly forbid the setting of numerical targets for providers, e.g., attaining a given number of new users or enrolling a number of clients in the use of specific contraceptive methods. Yet interviews with providers were excluded from the 1999 monitoring study (see León, 1999*c*). Lacking such interviews, the study could not explore providers' task goals.

- **Methodological Infrastructure.** By overcoming these problems the Year 2000 Monitoring study was expected to establish an improved evaluation methodology to monitor changes in provider compliance with MOH's family planning norms.

STUDY METHODOLOGY

This study was formulated as an improved follow-up of the study that the Population Council conducted in 1999. The study objectives were:

- To evaluate family planning providers' compliance with the quality of care norms of the Peru MOH at national level; and
- To leave with the MOH an improved monitoring methodology.

Sampling Design

To obtain a primary sample that was evenly distributed over the Peru territory, the 34 Health Directorates of the Peru MOH were matched to form 10 trios and two pairs. They were matched on the basis of cultural and regional considerations. From each trio (e.g., Loreto-Ucayali-Madre de Dios – all located in the low Amazonic jungle) and pair (e.g., Lima Sur-Lima Este – both located in the country's capital city), one DISA was randomly assigned to this study.[1] The resulting sample encompassed Arequipa, Ayacucho, Bagua, Callao, Cutervo, Huánuco, Junín, La Libertad, Lima Este, Ucayali[2], Moquegua, and Piura II (Sullana).

These DISAs can be regarded as an unbiased sample of the 34 Peru DISAs.

Sampling Procedures

In a second sampling step, hospitals, urban health centers, and rural health posts were selected within each DISA. In a third step, providers and/or clients were selected.

Hospitals. To include hospitals with high and low sterilization loads, all the hospitals encompassed in the 12 DISAs were selected for the study (n = 41). All were qualified to perform sterilizations. To study provider task goals, interviews were conducted with the family planning providers of each hospital with the objective of completing 12 interviews per DISA. To avoid loss of subjects and recall problems, 41 interviewers stayed during one month in the hospitals. In each hospital, the interviewer registered all the scheduled surgical interventions and sought to conduct exit interviews with all the patients sterilized in that period. In addition, she conducted up to 20 exit interviews with other family planning clients.

Urban Health Centers. Here the sampling took into account DISA matching criteria. If the matching criterion for a trio (e.g., Abancay, Ayacucho, Huancavelica) had been central-southern *Sierra*, only the health centers meeting this criterion were considered (e.g., health centers in low altitude areas of Ayacucho were ignored). The sampling was sequential. In each DISA it started with the largest health center of the largest health network, continued with other health centers of the same health network, and encompassed other health networks until 14 interviews with family planning providers per DISA were obtained. The same providers were visited by simulated clients who asked for services and observed the provider's service behavior. To encompass a larger diversity of client profiles, an observer stayed one day with the provider and observed interactions between the provider and real clients; some observers had to remain

on site longer until an interaction with a new user (new to the method delivered) took place. Another data collector conducted exit interviews with the clients involved in the observed interactions.

Rural Health Posts. To facilitate physical access at each DISA, the largest health center within the largest health network was selected; then four rural health posts supervised by the health center were randomly chosen. If less than four existed, the next largest health center was targeted to obtain the rural balance. Rural areas were defined according to the criteria of the Peru DHS (ENDES, 1997) as being less than 2,000 inhabitants. The procedure could not be fully implemented in the Cutervo and Bagua DISAs owing to scheduling requirements (e.g., only two days were allowed to travel from health center to health post) or security risks for the interviewers (e.g., crossing a turbulent river without life jacket); in these cases, the targeted health post was replaced by the nearest rural post. To explore family planning provider task goals, all of those on site were interviewed. To avoid loss of subjects and recall problems, one interviewer stayed during one week in each health post and performed client exit interviews. To overcome a selection bias limiting the sampling to persons who had accepted family planning, users of maternal-child health services, in addition to family planning clients, were interviewed.

Study Instruments

Six data collection instruments were designed by project personnel in close consultation with MOH and USAID/Peru staff. The instruments were pilot tested and adjusted prior to their use in data collection. Given the needed brevity of this report, these tools have only been utilized in part.

Provider Questionnaire (Hospitals, Centers, Posts). Focus: Provider's profession, contract status, relative importance of task goals, perceived numerical targets and their nature, consequences of failing to meet the targets, attitude towards clients who reject family planning, and knowledge of the *Norms*.

- **VSC Client Exit Interview (Hospitals)**. Focus: Sex, context of surgery, referral status, process of method choice, pressures exerted by providers, incentives and threats, knowledge of sterilization's consequences, satisfaction with service.
- **Family Planning Client Exit Interview (Hospitals, Centers, Posts)**. Focus: Pressures on clients (hospitals, posts), comprehensible information (centers).
- **Simulated Client's Observations (Centers).** This methodology is described in León *et al*. (2001). Focus: Essential information conveyed to the client.
- **Direct Observation of Provider-Client Interaction (Centers)**. Focus: Essential information conveyed to the client.
- **Maternal-Child Health (MCH) Client Exit Interview (Posts)**. Focus: Pressures exerted on clients.

Table 1 presents the effective number of cases (i.e., used in this report) and the months of data collection. Data collection started in June 2000 and ended in January 2001.

Data Processing and Analysis

To obtain unbiased responses from providers and clients, a number of questionnaire items were formulated as open-ended questions. For some of them (e.g., nature of targets), response categories were specified in advance and interviewers were

Table 1. ***Data-collection Instruments, Dates, and Effective Numbers of Cases***

Instrument	Data Collection	Facility and Number of Cases		
	Months	**Hospitals**	**Centers***	**Posts**
1. Provider Interview	August-September	111	174**	78
2. VSC Client Exit Interview	August-September	248		
3. Family Planning Client Exit Interview	August-September	820	141**	142
4. Simulated Clients' Observation	September-January		129	
5. Direct Observation of Interaction	June-September		141	
6. MCH Client Exit Interview	August-September			100

*The data pertaining to health centers were collected by an administratively independent operations research project (León, 2000).

**Collected in June-September 2000, as part of data collection of administratively independent OR project.

trained to check the category corresponding to the interviewee's response as soon as this was given. For others (e.g., expected consequences of meeting a target), the interviewer wrote-down the interviewee's free response and later analysts codified it using categories that were developed when the data base was completed. The quantitative analyses employed conventional statistical techniques aiming for maximal simplification. Infrequent deviations affecting individual rights of clients were given as much weight as major service trends.

MAJOR FINDINGS

To simplify the exposition of findings, the results of the study will be grouped into three sections, pertaining to voluntarism, information exchanged with clients, and provider task goals.

Voluntarism

According to the 1999 *Norms* clients should not be submitted to any pressure to use family planning or choose a particular method. To assess compliance with these norms, **exit interviews with recently sterilized patients** were sought at 41 hospitals. Nine of the hospitals did not perform VSC interventions in the one-month period of study. Interviewers at two of them heard that they would be delayed until the interviewers departed because providers were aware that the quality of care was not up to standards.

Eleven hospitals performed 1-5 VSC interventions, 16 hospitals performed 6-10 operations, and only 5 hospitals performed more than 10. The Honorio Delgado Hospital, Arequipa, performed 31. Only three patients preferred not to participate in the interviews. Of the total number of cases (n = 248), 14 were men. Of the 234 women, 31 percent were interval cases, of which one-third had given birth in the last six months. The others were postpartum (66%) and post-abortion cases (3%). VSC was performed in the context of a cesarean operation in 54 percent of the postpartum cases.

Six clients reported incentives and/or threats. Five said that they were offered incentives to persuade them to accept sterilization. Incentives reportedly offered included clothes for their children, food, work, and/or further care. There is no evidence that the incentives were actually provided. Additionally, this study documented threats in three cases, albeit the threats were not carried out because the clients accepted the operation. All the incentives and threats registered in the study were reported by users who received services in the interval (i.e., not postpartum) at a single hospital in the Peruvian highlands. The hospital had scheduled VSC interventions one month earlier. The VSC operations on the users who received incentives/threats took place on two consecutive

days. The six sterilized patients were re-interviewed by a project supervisor. Table 2 presents selected questionnaire responses corresponding to the six cases. Short case studies are offered in Appendix 1.

Table 2. ***Selected Questionnaire Responses from Six Sterilized Patients who Reported Incentives and/or Threats***

Questionnaire Item	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Sex[1]	Male and female					
Age[1]	Range: 26-37					
Number of children[1]	Range: 2-6					
How was it that he/she decided to be operated on	Home visit	Home visit	Home visit	His/her own	His/her own	Home visit
What was the reason he/she decided to be operated on	Family size	Told by Dr.	Family size	Family size	Family size	Family size
Who made the decision	Couple	Dr.	Couple	He/she	Couple	S/he&Dr.
Was he/she pressured to accept VSC	Yes	Yes	No	Yes	No	Yes
Who exerted the pressure on him/her	Provid.[2]	Provid.	-------	Provid.	-------	Provid.
Was offered anything to accept VSC	Yes	Yes	Yes	Yes	Yes	No
Was he/she threatened to accept VSC	No	Yes	Yes	No	No	Yes
Number of counseling sessions	2	4	4	2	4	1
No. of reversible methods discussed	4	6	5	6	6	4
Was client given a choice of methods	Yes	Yes	Yes	Yes	Yes	Yes
Told that would not conceive ever	Yes	Yes[3]	Yes	Yes	Yes	Yes
That she could desist at any moment	Yes	No	Yes	Yes	Yes	No
Surgery might have complications	Yes	Yes	No	Yes	Yes	No
Referred from a health post	Yes	Yes	Yes	Yes	Yes	No[4]
Days from last counseling to operation	3	1	1	9	1	1
Signed VSC request or authorization	Yes	Yes	Yes	---[5]	Yes	Yes
Sterilization regret	No	No	No	No	No	No
Would client recommend services to close relative/friend	Yes	Yes	Yes	Yes	No	Yes

[1]Data withheld to protect clients' identity. [2]Plus family. [3]See case in Appendix 1. [4]Counseled at hospital. [5]Signed two documents, yet could not identify them.

When the MOH conducted a corrective workshop for providers of the involved health network (*n* = 24), some of them volunteered comments stating that it would be hard to offer free/informed choices to clients given the pressures from above to meet numerical family planning targets

In a second DISA, one client said that she was sterilized against her and her husband's explicit desires. In another DISA, one client who had complications during delivery did not know that she had been sterilized. In a fourth DISA, one client said that she was sterilized despite that she changed her mind at the last moment. The respective case studies are presented in Appendix 2. These cases imply sterilizations performed without client consent, yet in the three cases the providers questioned the veracity of the clients' reports.

Only 66 percent of the clients in the hospital sample reported that the provider had given them the *Surgical Intervention Request.* These results are similar to those found in the 1999 study (León, 1999).

Client exit interviews conducted with general family planning users at hospitals (*n* = 820) yielded two cases of threats to accept contraception (in different DISAs), while 37 said that the provider had insisted on their using contraception. To assess pressures exerted on clients **in the context of maternal-child health services in rural health posts**, 100 exit interviews were conducted with women. Only 2 said that incentives and/or threats occurred (in different DISAs), while seven said that the provider had insisted on their using contraception. Similar were the responses obtained from **family planning users in rural health posts** (n = 142). Only one said that an incentive

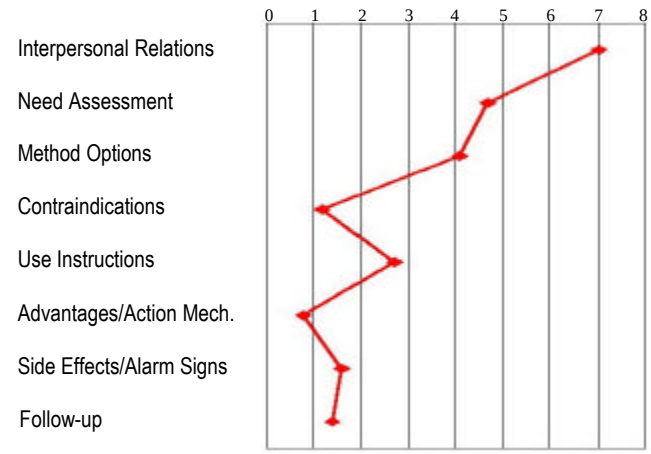
had been offered to her and 11 said that the provider had insisted on their using contraception.

Information Exchange with Clients

Information exchange with clients at health centers was measured by means of a *Service Test* comprising a client profile, trained simulated clients, and an observational checklist. The profile depicted a healthy woman who had used the rhythm method (got pregnant), DMPA (got amenorrheic), and condoms (disliked by husband) and wanted a more satisfactory contraceptive. If given the choice, she would choose combined oral contraceptives (pills). Fourteen simulated clients were trained to enact this profile as they responded to questions formulated by the provider during counseling. They learned also to fill out an 82-item observational checklist as soon as they left the premises. The items of the checklist were derived from the 1999 *Norms,* scored 1 (observed) or 0 (not observed), and grouped into 8 content areas at the rate of 9 items per area (see Appendix 3 about the *Service Test* and data collection).

Figure 1 shows the average summed scores per area. Providers excelled in treating the client respectfully. Their scores fell in mid-scale in diagnosing her family planning needs and offering pertinent method options. Of the expected behaviors pertaining to the method chosen by the client,

Figure 1. Average quality-of-care scores from Service Test (n = 118)



only offering use instructions was above two points. Screening the client for contraindications, informing her about other aspects of her method, and preparing for follow-up were clearly unsatisfactory.[3]

Table 3 presents details concerning specific items related to the method chosen by the client. Behaviors entailing instructions on how to use the method were more frequent than those having to do with method side effects, alarm signs, or contraindications.[4]

Table 3. ***Occurrence of Nine Expected Provider's Information-Exchange Behaviors Relevant to the Method Chosen by Simulated Clients, n = 118***

Service Test Item	Percentage
Told me that I have to initiate use of the pill on days 1-5 of menstruation	69
That I must continue with another package as soon as one is terminated	69
That the pill is very effective if taken every day	97
That if one white pill is forgotten I must take one as soon as I recall and then continue normally with the others	80
That I could experience nausea	77
That the discomfort is not dangerous and could disappear	25
That I should return to the health center if I have very intense headaches	21
Asked me if I have vaginal bleeding outside menses	2
If I have heart/circulation problems	36

To encompass a larger diversity of client profiles, **interactions between providers and real clients were observed at health centers, and clients were interviewed as they exited the premises**. A quality-of-care scale consisting of 27 items was constructed on the basis of items or combinations of items from the Client-Provider Interaction Observation and the Client Exit Interview. The items were grouped at the rate of 3 per content area (see Appendix 4 about this scale and data collection).

Figure 2 shows the distribution of scores for clients who chose hormonal

contraceptives or IUD. Like in the case of the *Service Test*, the average for interpersonal relations, needs assessment, and method options is larger than that for the areas entailing the method chosen by the client.

Figure 2. Average quality-of-care score from direct observation and exit interview with real clients (N=83)

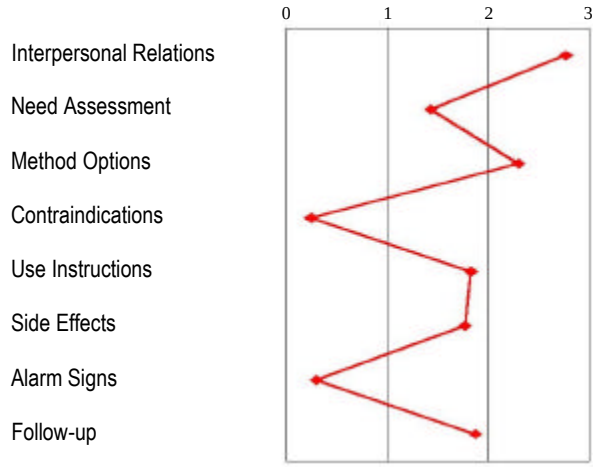


Table 4 shows selected observational results pertaining to provider behaviors in interactions with new users who chose combined oral contraceptives (n = 60). It can be noticed that, similar to what was observed by simulated clients, the average percentage for instructions about method use (41%) is greater than that for side-effects information (28%). Also paralleling the results of the *Service Test*, the contraindications area (either screening the client or telling her about the contraindication) emerges with the lowest average percentage (7%).

Table 5 shows equivalent results for the case of new users who chose the DMPA (i.e., Depo-Provera) injectable (n = 81). Again, instructing the client about method use showed a greater percentage than addressing contraindications (37% versus 7%). On the other hand, informing the client about side effects showed a surprisingly high average percentage (47%). These results are positively biased. Data collectors reported that providers attempted to show their best under observation.

Table 4. ***Occurrence of Nine Expected Provider's Information-Exchange Behaviors in Interactions with Real New Users of Pills at Health Centers, n = 60***

Items	Percentages
Told client to continue with another package as soon as one is terminated	48
That if one white pill is forgotten, should take one as soon as she recalls and continue normally	48
That if more than one is forgotten, client must suspend pills and wait menstruation	25
That she could experience nausea	38
That she could have headaches	52
That she could experience breast tenderness	5
That she could change to another method if she did not tolerate the side effects	17
Heart/circulation diseases addressed as contraindications	7
Liver diseases addressed as contraindications	7

Table 5. ***Occurrence of Nine Expected Provider's Information-Exchange Behaviors in Interactions with Real New Users of DMPA at Health Centers, n = 81***

Items	Percentages
Told client that she has to initiate use of DMPA on days 1-5 of menstruation	26
That injection is applied every three months	73
That allowable window surrounding quarterly injection date is two weeks	5
That menstruation may disappear completely or in part	74
That irregular bleeding or spotting may occur	53
That temporary infertility of 6-12 months might follow stopping method	7
That she could experience weight gain	43
Abnormal vaginal bleeding addressed as a contraindication	2
Breast cancer addressed as a contraindication	5
Liver disease addressed as a contraindication	11

Provider Task Goals

To assess the **social value of several task-related goals to providers**, we asked them to rank-order the personal importance of 10 items presented in cards. "Assist client in informed method choice" (average of "Talk to user about several contraceptive methods" and "Make sure that it is the user who chooses the contraceptive method") had the first rank (average rank = 2.95), followed by "Assist client with respect to the method chosen" (average of "Screen client for contraindications", "Make sure user knows how to use her method", and "Talk to user about the method's side effects" (average = 4.73). The third rank was occupied by "Provide orientation to users about STIs/AIDS" (average = 6.49), followed by "Compliance with regulations" (average of "Fill out registers and reports", "Comply with facility's scheduled hours", and "Comply with directives from supervisors" (average = 6.89). The last rank pertained to "Enroll a high number of new users" (average = 7.64). Since the providers were aware that an evaluation was on-going, their responses expressed the social value of the items to them. It is noteworthy that offering high-quality services to clients is a dominant provider social value.

Table 6. ***Provider Training on and Knowledge of the Norms of the National Family Planning Program (1999) as Reported by Providers, by Type of Facility, n = 363***

Percentages for: *Type of Facility*	Received Training	Knows Them in Detail	Read Them Completely	Read Them by Sections	Perused Them	Does Not Know Them At All
Hospitals	30	8	19	44	15	13
Health Centers	44	6	40	37	12	4
Health Posts	18	3	11	36	14	36

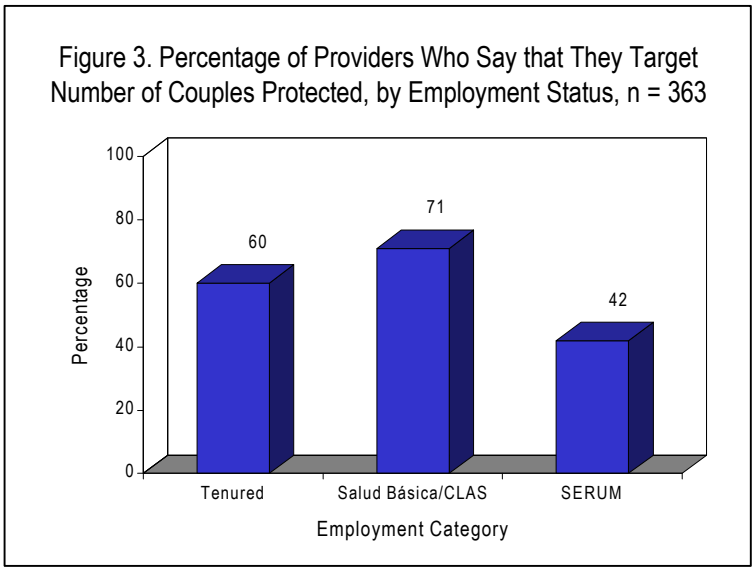
We assessed **provider knowledge concerning the 1999 Norms** by means of several questionnaire items. Training and better outcomes were found to be concentrated in health centers (see Table 6). To assess **compliance with the Norms pertaining to numerical targets**, the questionnaire item was worded differently in health centers (wherein the data were collected by the administratively independent OR project initiated in June 2000) and the other facilities (i.e., the hospitals and rural health posts targeted by the monitoring study in August 2000). In health centers we asked, "Do you currently work with quantitative service targets? That is, targets concerning number of users in general, new users, continuers, couples protected, or quotas for specific methods?" In hospitals and rural health posts the questionnaire item read, "Currently, have you been assigned quantitative work targets over the last year? That is, targets entailing number of users in general, new users, continuers, couples protected, or quotas for specific methods?"[5] The percentage of positive responses ranged from 43 percent in Bagua through 97 percent in La Libertad.

Significantly more providers in centers (88%) than in posts (72%) reported numerical targets (Chi-square = 9.66, $p < .01$). This is explained by the greater presence of technicians ($n = 40$) in posts. Only 45 percent of the technicians admitted numerical targets versus 75 percent of the nurse-obstetricians ($n = 276$, chi-square = 14.3, $p < .001$) and 94 percent of the nurses ($n = 18$).[6] Half the general practitioners in the whole sample ($n = 17$) admitted targets (53%). Even smaller was the percentage of hospital providers who admitted numerical targets (39%). The difference with centers (88%) and posts (72%) is explained by the greater presence of ob-gyn physicians ($n = 9$) and tenured providers in hospitals. Only 11 percent of the ob-gyn physicians reported targets.

Tenured providers ("nombrados", *n* = 139) have permanence in their jobs. Those who have to renew their contracts periodically, generally every three months, include providers hired by the *Salud Básica para Todos* (Basic Health for All) project (*n* = 114) and the CLAS, i.e., *Comité Local de Administración de Salud* program (MOH-community agreement, *n* = 31). Providers with *Salud Básica* or CLAS reported numerical targets (79%) to a greater extent than tenured providers did (68%; chi-square = 3.83, $p < .06$). SERUM (52%) and personal-service providers (48%) showed the lowest percentages. SERUM (Rural and Urban/Marginal Service, *n* = 33) is a program for new professionals lasting one year. Personal services contracts (*n* = 27) is a category that emerged in the questionnaire's pilot-testing.

To specify **the nature of the targets**, we asked "For whom are the targets" in health centers and "For whom are you assigned targets" in hospitals and health posts. In both questionnaire versions the response options were users in general, new users, continuers, and couples protected, in this order. Considering only the responses of the providers who reported targets, number of couples protected emerged with the greatest percentage, in health centers (92%) as well as in hospitals (81%) and rural health posts (91%). The percentages (considering <u>all</u> the providers, *n* = 363) ranged from 39 percent in Bagua to 97 percent in La Libertad.

The difference between Salud Básica/CLAS and SERUM was significant (chi-square = 5.6, $p < .02$). Again, we observed a difference between types of facilities. In hospitals, only 32 percent of all the providers referred to couples protected as a target. The percentages were 81 in centers and 65 in posts. Figure 3 compares the main employment categories.



Providers were asked **to further specify their targets** ("What do you set targets for? Programmatic targets?[7] Other? Method quotas?"; multiple response). According to the MOH, targets are for programming, including logistic purposes and other planning or management functions. Some providers' responses, however, revealed considerable confusion with the concept of programming target. A few providers said that programmatic targets meant home visits.

Half of the providers said that their targets were programmatic while 36 percent said that they were method quotas and 1 percent referred to other types of targets. Sixteen percent of the total number of providers in the sample said that they implemented method quotas which were not programmatic targets. Reporting of method quotas ranged from 17 percent in Callao to 61 percent in Arequipa and Moquegua. More than 90 percent of the providers who set method quotas said that they applied to the condom, pill, injectable, IUD, and vaginal tablets. For VSC, the percentages were 74 percent (female) and 67 percent (male). Less than 55 percent of the providers mentioned other methods or said that the quotas applied to "All methods".

To assess **the expected consequences of meeting the target**, we asked "What would happen if you attain the target?"[8] Out of the 253 providers who reported targets, 27 percent said that nothing would happen while others said that they would be

congratulated (25%), or would feel satisfaction (16%). Others said that they would be meeting the targets (10%) or be working as expected (10%). Six percent would expect to be contracted again, 6 percent to receive a gift, and 6 percent to have their quotas reprogrammed.

To assess **the perceived consequences of failing to meet the target**, we asked "What would happen if you do not attain the target?" Out of the 253 providers who worked with targets, 19 percent said that the quotas would be reprogrammed, 18 percent said that nothing would happen, and 15 percent said that the supervisors would assess why the target was not attained. More personal consequences included being reprimanded (27%), feeling worried (13%), being fired (13%), and being punished in several ways (12%), including being sanctioned, pressured, threatened, rotated, or given a lowered salary.

Table 7. ***Expected Consequences of Target Attainment/Failure as Reported by Providers (Open-ended Questionnaire Items), by Employment Status, n = 253***

Percentages for:	Attaining Target			Failing to Attain Target		
Employment Category	Congra-tulated	Receiv-ing gift	Contracted Again	Feeling Worried	Being Fired	Other Punishments
Tenured Providers	23	6	2	13	4	12
Short-term Contract	27	7	10	12	21	11

Table 7 compares tenured providers with those under *Salud Básica*/CLAS in terms of expected consequences of attaining and failing to attain the numerical targets. The difference for "Being contracted again" is borderline in statistical significance (chi-square = 3.8, $p < .06$) and that for "Being fired" is significant (chi-square = 11.1, $p < .001$). The

table does not include an apparently paradoxical result entailing "Feeling of Satisfaction" as a consequence of attaining the target (tenured providers = 62%, *Salud Básica*/CLAS = 25%, chi-square = 13.0, $p < .001$); this result can be explained by the negative effects of extrinsic rewards/punishments on intrinsic motivation (Deci *et al*., 1999).

To assess **the association between numerical family planning targets and the quality of care**, we computed (for the total group of nurse-obstetricians who said that they had targets) the correlation between the severity (on a four-point scale) of the expected negative consequences of failing to achieve the target and the quality-of-care score derived from the observations of simulated clients in the *Service Test*. Severity of consequences went from "Nothing happens" (0) through "Being fired" (-3). The intermediate points entailed slightly negative consequences (-1, e.g., "Provider will assess reasons for failure") and more severe negative consequences (-2, e.g., "Being transferred"). The resulting correlation was negative, highly significant, and considerably large ($r = -.63$, $p < .01$), revealing a consistent trend whereby the stronger the provider's internal and external pressures to achieve numerical targets, the more positive are the general consequences for the clients in terms of quality of care. This is an unexpected result.[9]

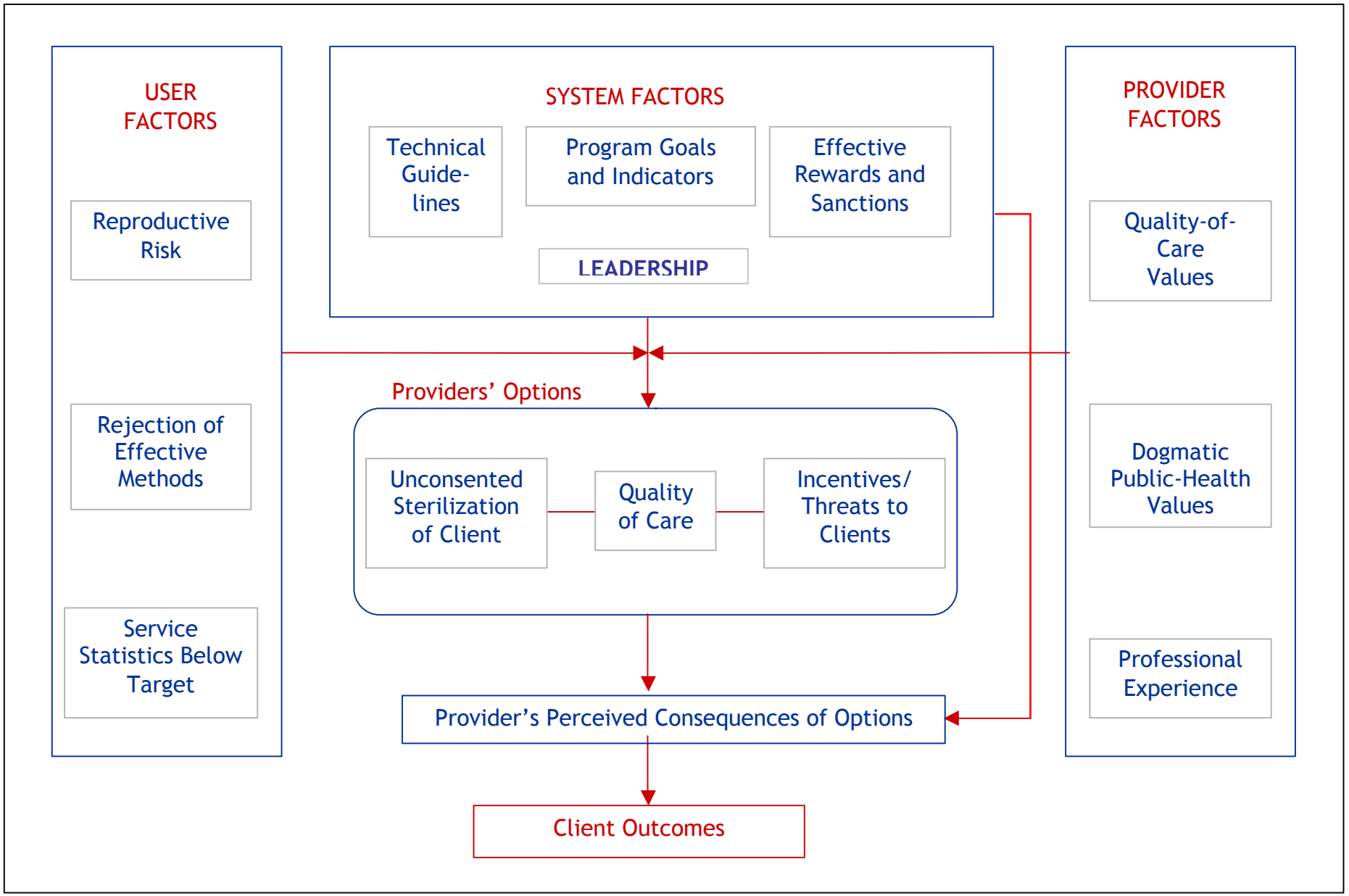
Explanatory Framework

Some results of this study are contradictory. Consider the relationship between targets and the quality of care. According to providers of the health network in which clients were pressured to accept sterilization, the quality of care is interfered by the pressures received from above to attain numerical targets. On the other hand, our correlation analysis at national level revealed that the greater the pressures felt by providers, the

better was the quality of their services. A conceptual framework is needed to reconcile contradictions and parsimoniously account for the three central findings of this study, i.e., (a) the six cases of incentives/threats to clients to accept sterilization that were observed in a single health network, (b) the three cases of unconsented sterilization in the postpartum likely to have occurred in three DISAs, and (c) the general efforts of providers to offer free and informed choices to clients. Figure 4 offers an explanatory framework that considers the interaction of user, system, and provider factors.

Program Goals and Indicators. In the past the MOH (1995) sought to increase contraceptive prevalence. Current goals in the family planning area point to the provision of high quality services in response to the expressed needs of individual clients (*Norms,* 1999); however, the quality of care is not assessed systematically. In contrast, the MOH performs an annual goal-setting process as it - seeking to respond to public demand and reduce the unmet need for contraception - establishes "programming targets".[10] The targets are programmed for DISAs and individual facilities on the basis of an 8-step procedure that uses data from censuses, the Demographic and Health Survey, and service statistics (see Appendix 5 about the 2001 target-setting for the Callao DISA and its facilities). The procedure is centered about an indicator of programmatic progress and yields an expected method-mix. The indicator is the yearly number of couples protected (YNCP), constructed on the basis of conversion rules that assign 1 YNCP for one sterilization or one IUD insertion performed, .25 YNCP for one DMPA injection applied, .077 YNCP for a blister of pills delivered, .10 YNCP for 10 condoms or vaginal tablets dispensed, etc. The expected YNCP for a facility is known to the facility's providers and, as this study showed, for a high percentage of providers becomes a production target.

Figure 4. *Hypothesized Causal Links Leading to Client Outcomes*



Effective Rewards and Sanctions. The MOH lacks a formal and working system of rewards and sanctions pertaining to either the quality of care or the targets. In this study, 18 percent of the providers who reported targets said that nothing would happen if they failed to attain them, while other 19 percent said that the targets would be reprogrammed. On the other hand, the short-term contracts given by *Salud Básica* and CLAS to about 50 percent of the family planning providers nationwide lend themselves to distorted applications or distorted perceptions on the part of providers. This study showed that 21 percent of the providers under short-term contracts who were under targets believed that they would be fired if they did not achieve their family planning targets.

Service Statistics Below Target. It is common knowledge inside and outside the MOH that, to meet the goal of reducing unmet need for contraception in the surrounding communities, providers perform home visits to enroll new family planning users. In some communities providers meet with a lack of response and cannot meet their numerical family planning targets. The health network in which this study found incentives/threats was located in a backward highland area in which traditional values inhibit acceptance of contraception. Five of the six sterilized patients who reported incentives/threats had been enrolled by means of home visits.

Provider's Options. The study findings suggest that an individual provider will consider giving incentives to clients or threatening them to accept sterilization if: 1) he/she works with production targets and 2) is behind schedule in the production of YNCPs (for one sterilization counts more than the delivery of other methods in the calculation of YNCP) or the sterilization itself is an unattained target and 3) is under a

short-term contract with a project or program that uses YNCP or method-mix as indicator of job performance. This needed combination of factors would explain all the cases of incentives/threats identified in this study as well as their relative infrequency. An alternative option, performing the sterilization without knowledge of the user, is examined below.

Client Reproductive Risk and Rejection of Effective Method. In connection with target concerns or independently of them, the provider may consider performing an unconsented sterilization if the client has reproductive risk and does not accept an effective family planning method. Client's reproductive risk was an extended concern among family planning providers in the past that has subsided but not disappeared.

Dogmatic Public-Health Values. For some providers, the coincidence of reproductive risk and rejection of effective methods may justify violating the principle of family planning voluntarism. Both authors of this report have heard from some MOH providers that they have the ethical responsibility to take care of situations in which the client puts her life or health in risk. According to these dogmatic public-health values, the client's health is more important than her free choice.

Perceived Consequences. The study findings suggest that providers considering incentives/threats or unconsented sterilizations will violate the voluntarism principle to the extent that they do not anticipate sanctions within the system. An unconsented sterilization can remain more easily undetected by clients and others if it is performed in the context of a cesarean operation. According to three clients, they were sterilized against their wishes (see Appendix 2). Like in the previous monitoring study (see León,

1999, Appendix F), the three cases were in the postpartum and all involved reproductive risk. Two of them occurred in the context of a cesarean operation. In all the cases the providers claimed that the clients' allegations were untrue. We cannot prove the violations of voluntarism, yet cannot disprove the clients' allegations either. However, we can hypothesize that - in a very small percentage of cases - clients with reproductive risk who reject effective contraceptive methods are sterilized without their knowledge or consent by providers with dogmatic public-health values who do not anticipate sanctions within the system.

Client Outcomes. The six cases of incentives/threats to accept sterilization were implicitly confirmed by providers of the same health network who stated that it would be hard to maintain free-choice standards in the face of the pressures to meet numerical targets that came from above. One of the unexpected findings of this study was that these violations of voluntarism were accompanied by quality-of-care elements in the family planning services received (e.g., information given to the client, method options). Their coexistence is remarkable.

Leadership. A further puzzle is posited by the finding that providers' expectations concerning negative consequences of failing to meet targets were associated with higher levels of quality of care as measured by the *Service Test*. The study results could be explained by the concept that the DISA directors and/or family planning coordinators who effectively promoted the quality of care among their subordinates also promoted attainment of numerical family planning targets. The concept of leadership would parsimoniously explain the correlation.

Provider Quality-of-Care Values. Organizational leadership entails persuading subordinates to accept as personal objectives the organizational goals. This suggests that quality of care and numerical targets may be part of an integrated set of public health values at the MOH. The study findings showing that quality of care, including voluntarism, is a prevalent social value for most MOH providers and that most of them reported to work with targets is consistent with this conclusion.

Technical Guidelines. The 1999 *Norms* define with great precision what is quality of care in family planning and present this option as the only accepted way of delivering family planning services. They also state that "no authority, at any service or administrative level will set obligatory targets or quotas of persons or contraceptive methods for facilities or health personnel" (*Norms,* 1999, p. 41). Nonetheless, the *Norms* also state that service performance is evaluated in terms of "quality, integrality, and production" (p. 38). At the MOH, "Production" has always meant number of users and similar numerical output.

Provider Professional Experience. The 1999 *Norms* were not available to all providers at the time of this study and not all those who had received them were familiar with their details. The *Norms,* however, are not the only sources of quality of care criteria. Adequate services can be implemented by providers who have had the needed training and/or professional experience within or outside the MOH.

UTILIZATION

The utilization of study results has focused on the health network in which violations of voluntarism were concentrated. As soon as the incentives/threats were detected (León & García, 2000*a*), FRONTIERS coordinated with the National Family Planning Program the organization of a corrective workshop for supervisors and providers. Due to staff changes at the Program, the workshop was delayed until 5-7 February 2001. On the first day, the MOH's Director of Maternal Health and the DISA Director met with DISA and network family planning coordinators and six hospital providers to discuss the Program's position concerning numerical targets. Then a counseling trainer took over and presented a balanced counseling strategy developed in the context of a parallel operations research project (León, 2001). In the next two days, providers from health centers and posts joined the workshop (n = 24). At the end of it, center and post providers confided to the trainer and the study coordinator that the application of informed-choice principles is severely constrained by their need to meet contraceptive targets set by the CLAS (Lagos, 2001).

To alert the community about possible recurring violations, FRONTIERS coordinated with the Program the design of a radio campaign. MOH's Communicator Liliana Rojas designed a script (see Appendix 6) that was pilot tested on site in Spanish and Quechua on 15-16 March 2001. The radio campaign was aired in late April.

Earlier, USAID/Peru had informed the Minister of Health that two elements of the Tiahrt Amendment's Requirements for Voluntary Family Planning Projects (threats and incentives to clients) had been violated and the Agency was obliged to denounce the violation to the U. S. Congress, which it did on 30 January 2001.

CONCLUSIONS AND RECOMMENDATIONS

1. **Violations of Voluntarism Related to Targets.** The principle of voluntarism in family planning is violated in MOH facilities in exceptional cases in which clients are threatened or offered incentives to accept sterilization. This represents a violation of the Tiahrt Amendment's Requirements for Voluntary Family Planning Projects of the United States Congress. Some declarations of individual providers suggest that the incentives/threats originate in pressures felt by providers to meet numerical family planning targets. Whereas this relationship was not proved in the study, it should be seriously considered. Its recognition by the MOH may represent a start in the way to a solution.

2. **Violations of Voluntarism Due to Dogmatic Values.** Similarly exceptional were the cases of clients who claimed that they had been sterilized against their wishes. Their versions were contradicted by the providers'. However, there is anecdotal evidence suggesting that some providers believe that the client's health is more important than the free choice of methods and, in the presence of client's reproductive risk and rejection of effective contraception and in the absence of expected sanctions, may perform a sterilization against her wishes. To prevent the occurrence of unconsented sterilizations, prenatal care at the MOH must stress voluntarism in family planning and cesarean operations must be closely monitored.

3. **Comprehensible Information.** Giving an informed choice of methods to clients is a dominant provider value. Providers display a sustained effort to assist clients in method choice. Yet, they spend too much time in the initial phases of

counseling (diagnosing client needs, offering method options) and focus too little on the method chosen by the client. They are generally more exhaustive instructing clients on method use than screening them for contraindications or alerting them about side effects. A service strategy that stresses balanced counseling and makes intensive use of job aids for providers and detailed written information for clients is needed. The MOH has recently tested a job aids-assisted *Balanced Counseling Strategy* that could be scaled-up nationwide.

4. **Numerical Family Planning Targets.** Number of couples protected is a production target and reporting requirement for many family planning providers. This does not represent a Tiahrt violation. The MOH's *Norms of the National Family Planning Program (1999)* forbid the use of numerical targets in service delivery, there is no formal imposition of predetermined targets on individual providers at the MOH, and an explicit system of rewards or punishments related to target attainment does not exist. Nonetheless, production targets are present in the perception of many providers and condition their expectancies and fears. For example, a significant proportion of providers working under short-term contracts fear being fired if they do not meet their numerical family planning targets. On the other hand, the presence of targets seems to have positive and negative effects on clients' care. On the positive side (for the clients), provider expectancies of being punished for not meeting the target are associated with higher levels of quality of care. On the negative side, they occasionally lead to violations of voluntarism. Even though, statistically, the positive consequences seem to be greater than the negative effects, the latter are ethically unacceptable. Hence, the MOH is

recommended to take action in this area.

5. **Public Health Goals Related to Targets.** The production targets appears to percolate from the MOH's procedure to set programming targets, in which it establishes the expected yearly number of couples protected and the expected method mix for each DISA and for each facility. In so doing, the MOH seeks to prepare its operations to respond to public demand and to reduce the unmet need for family planning, i.e., the number of women in risk of pregnancy who do not wish to have children, yet are not using family planning as measured by DHS. The latter is an abstract indicator of public health and its reduction implies converting nonusers into users. A strategy based on this concept of unmet need, however, may be called into question on practical grounds other than generating violations of voluntarism. A study conducted by the Population Council in Peru revealed that "family planning programs may be more effective if they emphasize eliminating unintended pregnancies among women who are already practicing contraception than if they focus on persuading nonusers to become users" (Jain, 1999). Public health and client rights may be well served if the MOH completes the transition to a client-oriented paradigm by making its goal-setting process, including target-setting, conform to the explicit goals of the *Norms of the National Family Program* (1999) rather than to the goal of reducing the abstract unmet need for contraception.

6. **Monitoring System.** The sampling procedures and data collection innovations introduced in this study improved the monitoring system's capacity to detect violations of voluntarism at hospitals. The results of the study in health posts were

consistent with the hospitals findings, yet did not contribute additional results. The addition of direct observation of the client-provider interaction at health centers confirmed the observations of simulated clients but did not contribute idiosyncratic findings, either. The monetary cost of the monitoring system could be substantially reduced with no significant loss of precision if it were limited to interviews at hospitals and simulated clients' visits to health centers.

Notes

[1] The second DISA of each trio or pair was assigned to a parallel operations research project designed to improve the quality of care. The third DISA of each trio was left untouched.

[2] The DISA randomly chosen had been Madre de Dios. However, Ucayali seemed more comparable with Loreto, the DISA randomly chosen as experimental site of the parallel OR study.

[3] The items were scored according to their position in the sequence of counseling steps. For example an observed provider behavior concerning screening the client for contraindications counted 0 if it was observed when the client had not yet chosen a method.

[4] Use instructions included items such as "The provider told me that I should start using the pill in the first five days of menstruation", "That I should continue with another package immediately upon finishing one", and "That, if I forget to take one white pill, I should take one immediately after I remember and then continue taking the others at the usual time". Side effects and alarm signs included items such as

"Told me that I could experience nausea and/or dizziness", "That these experiences of discomfort are not dangerous and could disappear", and "That I should return to the health center if I have very strong headaches". Contraindications included items such as "Asked me whether I have vaginal bleeding outside menstruation", "Whether I have high blood pressure (or measured it)", and " Whether I had had a Papanicolaou".

[5] The wording of the questionnaire employed in health centers was agreed with USAID/Peru's Dr. Lucy López and accepted by the MOH. The wording of the questionnaires used in hospitals and rural health posts was agreed with Dr. Gracia Subiría, appointed by the MOH as its representative in the revision of data collection instruments. By then, the USAID/Peru monitor was overseas.

[6] If the difference in wording of the respective questionnaire items across facilities explained the observed differences, the responses at hospitals and rural health posts would have to be similar, for the same questionnaire was employed in both types of facility. Yet, in the specific case of the nurse-obstetricians, 100% in health posts, 89% in health centers, and only 51% in hospitals reported numerical family planning targets.

[7] This option was solicited by Dr. Gracia Subiría.

[8] It was clear to providers throughout the interview that the questionnaire pertained to family planning. The data collectors were trained to make sure that at all times during the interview the concept of "target" referred to the definition used in the questionnaire, i.e., "targets concerning number of users in general, new users, continuers, couples protected, or quotas for specific methods". Since most providers said that couples protected were

their targets, the subsequent questionnaire items, dealing with consequences of attaining or failing to attain targets, implicitly pertained to couples protected for most of them.

[9] Client exit interviews conducted with general family planning users at hospitals (*n* = 820) yielded two cases of threats to accept contraception (La Libertad, Junín), while 37 said that the provider had insisted on their using contraception. To assess pressures exerted on clients in the context of maternal-child health services in rural health posts, 100 exit interviews were conducted with women. Only 2 said that incentives and/or threats occurred (Ucayali, Cutervo), while seven said that the provider had insisted on their using contraception. The responses obtained from family planning users in rural health posts (n = 142) were similar. Only one said that an incentive had been offered her (Cutervo) and 11 said that the provider had insisted on their using contraception. These figures may underestimate the extent of the problem, for clients may be reluctant to report pressures.

[10] Dr. Gracia Subiría, coauthor of the 1999 *Norms* and former MOH staff in charge of Evaluation and Supervision at the National Family Planning Program, described the process of target setting to the authors and authorized them to quote her (Lima, 9 August 2001). Lic. Nelly Peña, family planning coordinator of the Callao DISA explained the application of the system in her DISA (Callao, 13 August 2001). The process in EsSalud is similar according to Verónica Espinoza, Deputy Manager of External Services. Personal communication to Federico León and Toni Martin. Lima, 26 July 2001.

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Appendix 1

Case Studies Entailing Incentives/Threats

- Case 1 first thought about VSC two months before the operation, when a health provider visited him/her at home. The provider said, *"Get a (sterilization). You have too many children. The surgery is quite normal."* The client felt pushed *"by my family and health providers. They pushed a lot."* He/she was offered, *"food, clothes, work"* by providers.

- Case 2 first thought about VSC three days before the operation, when health providers visited he/she at home. He/she accepted the sterilization *"because the doctor told me"*. Asked if he/she was offered incentives, he/she said, *"Yes, they forced me. They told me they were going to give me clothes for my baby. They were going to help me if I got the operation."* Asked if he/she was threatened, he/she said, *"If I didn't accept I would have had to pay for services at the health post and I wouldn't get any help or food."* He/she felt pushed *"by all nurses and the nurse-obstetrician. They forced me to accept by offering me food."* When he/she was asked whether he/she had been told that after the operation he/she would not have children ever, he/she said: *"Yes, and that I could have children again after four years."*

- Case 3 had been thinking about VSC during three years. The providers who visited him/her at home said, *"You have to decide for the (sterilization) because having lots of children is a problem and you won't have enough money for food"*. They offered clothes and food and, yet, he/she did not feel pressured. However,

he/she later felt threatened: *"My leg is infected. They told me that they would deny services to me if I didn't accept the (sterilization)."* He/she made a joint decision with his/her partner.

- Case 4 had made the decision on his/her own. Yet providers offered him/her clothes and food for his/her family if he/she accepted the operation. He/she did not feel threatened because he/she wanted the VSC, yet felt pressured *"by the health provider. He said that if I didn't accept the operation my children would not get care at the health post."*
- Case 5 did not feel pressured or threatened. He/she had thought about VSC for five months and made the decision with his/her partner. Nevertheless, *"The nurse-obstetrician offered clothes for the baby."*
- Case 6 made the decision with the provider. In his/her case the threat was subtle and psychological in nature. The provider said *"Don't let me down"*, and he/she felt threatened.

Appendix 2

Case Studies Entailing Possible Unconsented Sterilizations

Case # 1:

Department of La Libertad. Housewife, 41 years-old, 7 living children, illiterate. Says she was using the pill prior to her first pregnancy, 20 years ago. Owing to her blemished face and the strong headaches she suffered, she decided not to use any family planning method ever. States that she did not want the tubal ligation "because it causes damage, it is bad, we die when it is infected."

She had her last child on 16 August 2000. Her six prior deliveries were normal. During her last pregnancy she attended the health center on 10 January, 26 July, and 31 July. On such occasions her weight and arterial pressure were taken and her uterine alteration and fetal movements were observed. She was told that "if she does not want to use contraceptive methods, then she should receive a tubal ligation."

She noticed the first signals of readiness on 16 August at 1:00 p.m.. The traditional midwife told her that "they should go to the health center, for the baby was coming with the cord ahead. The placenta is going to come ahead and the baby behind." The woman and the midwife said that the former went immediately to the health center, where she stayed 7 hours. The woman says that the attendants tried to get the baby out, broke a baby's arm, and failed. ("The baby came with one arm ahead and they broke it. They attempted to put it back inside but could not. I went to the hospital with the baby's arm outside.") The woman was taken to the hospital at 8 p.m. and was submitted to a cesarean operation at 10 p.m.

According to the woman, she was told at the hospital: "You have to receive a ligation to avoid having further children. This time the baby came with the arms ahead, next time

will come with the legs ahead. You older people should not have more children. We have to ligate you. But I did not want." She did not want the ligation owing to fear. She was afraid it could ache and she might be unable to buy medicines. Her husband did not want it either. It seems that a cousin of his had died two years ago due to an operation. He was called upon to sign the authorization for a voluntary surgical sterilization but he declined. "The doctor asked my husband to sign but he did not want to. Then the doctor told him that he would have to pay cash for the medicines (as a threat)."

The woman did not sign any paper, yet does not know whether her digital print was obtained. The husband only signed authorizing the cesarean, not the sterilization. When he declined to sign, he was asked to leave. She was told, "The next time you come with more children we will not attend you because you do not want to take care of yourself." One day after the partum, a nurse came and asked her "How do you plan to take care of yourself?" "I do not", she answered. "Then I will give condoms to your husband" was the nurse's response. The doctor asked her if she was feeling well and asked to talk to her older daughter. "They (referring to her parents) did not want to use family planning, he said. That's why we have ligated her. Do not worry, nothing is going to happen. And the medicines for sterilization are free. I have ligated her because of the risk, because your mother can die if she gets pregnant again. She did not want, but anyway we did it. Try to tell her nicely that we did."

It seems that the daughter complained and the doctor said, "We have done good to her, not ill." On 18 August the woman learned from her daughter that she had been sterilized. She considers that the health center caused damage to the baby, yet at the hospital she was well treated. "They gave me clothes for the baby, because I did not have." When asked whether she was offered anything during the prenatal visits, she said that she was offered food and clothes in exchange for accepting a tubal ligation. "They support you if you accept."

On the other hand, the midwife said that the woman knew in advance that she needed a cesarean because the fetus was in bad position. It seems that she remained several hours

in the health center because the ambulance was delayed. The midwife said that she had suggested the woman to accept the tubal ligation and that "she in fact wanted to receive the ligation.".

The doctor, in turn, said that when a woman comes to deliver at the hospital "and we see that she has 3, 4, or 5 children and more than 30 years, we suggest her to accept a ligation, and ask the husband to sign. If she comes for an emergency cesarean, we tell her at that moment, 'Can we ligate you?' If she says No, we do not do it."

With respect to the case of this case study, the doctor said that the relatives were involved. "There should be a document signed. Otherwise, we do not ligate." The doctor does not remember who signed, yet is sure that a signature was produced. He said that only in case of mental illness is a surgical intervention performed without prior patient signature.

Comment: There are unreal elements in the woman's account concerning damage to the baby. However, not all the story has to be regarded as fabricated.

Case # 2:

Bagua. 32 years-old woman, with 5 living children. Received three family planning counseling sessions in the health post. She says it was difficult to understand what she was told about voluntary surgical contraception. The provider asked whether she had understood. She feels she did not have complete information about the method. The provider recommended her to accept the sterilization, saying "you have to receive a ligation to avoid having to carry on with too large a family." There were no threats nor incentives. She thought of the ligation one month ago. She wanted the intervention and made the decision with her partner. However, now she regrets it owing to a persistent ache in the lower area. Just before the operation, she told the doctor she did not want to be operated on, yet the doctor did not pay attention to her and went ahead with the operation.

Comment: There are no inconsistencies in this case.

Case # 3:

Junín. This is a 32 years old woman with 4 children who appears in hospital records as sterilized. During the postpartum interview, however, she showed that she was not aware of having received a tubal ligation. She went to the hospital on 7 September to deliver and was submitted to an emergency cesarean owing to signs of eclampsia. The pregnancy had been complicated and she had been hospitalized before. She says she did not sign any document. Presently she feels in good health.

Comment: This seems to be a straight-forward case of unconsented sterilization.

Appendix 3

Service Test

Quality of care (QoC) was measured by means of a client profile, trained simulated clients, and an observational checklist (see León *et al.*, 2001 about the *Service Test*). In this instance the client profile depicted a healthy woman who had used the rhythm method, condoms, and DMPA and wanted a more satisfactory contraceptive; if given the choice, she would choose combined oral contraceptives (COCs). Simulated clients were trained to enact this profile as they responded to questions formulated by providers during service delivery. They learned also to time session length and fill out a checklist pertaining to 80 expected provider behaviors as soon as they left the premises. The items, derived from the MOH's (1999) *Norms*, pertained to 8 different themes; scoring criteria in terms of sequence (pre-choice, post-choice) were derived from the new strategy. The sum of observed-not observed items (1s or 0s) yielded a QoC score per theme as well as a global score per counseling session. Most providers were exposed to visits by 2 different simulated clients on successive days. For purposes of the present preliminary partial report, the two sets of data were averaged and the *Service Test* was streamlined to 9 items per area. Complete data were obtained for 4 to 17 providers per DISA, making a total of 129 providers. Individual provider QoC scores ranged from 11 to 54. DISA average scores ranged from 19 to 31. Both were normally distributed according to Kolmogorov-Smirnov tests.

Appendix 4

Quality of Care Measurement Based on Real Clients

The scale consists of 27 items or combinations of items from the Client-Provider Interaction Observation Guide (OG) and the Client Exit Interview (EI), grouped per content area at the rate of 3 per area. Areas covered include: 1) Interpersonal Relations (How do you feel you were treated by the provider?, Did you feel the provider cared about your health?, Did it seem to you that the provider was hurried? [inverse scoring], all from EI). 2) Need Diagnosis (Whether the following issues were addressed: Desire to have children, Attitude of partner toward contraception, Method currently used or used in the past, all from OG). 3) Method Options (Whether client had already chosen a method was addressed, according to OG; Did you feel that you could choose between several methods? and Do you feel it was you who chose the method?, both from EI). 4) Contraindications (One or more addressed by provider, Two or more addressed, Three or more addressed, all from OG). 5) Use Instructions (Concerning the method chosen, did the provider explain to you how to use the method? and Two spontaneous correct responses about use, both from EI. Three or more use instructions pertaining to method chosen addressed by provider, from OG). 6) Side Effects? (Concerning the method chosen, did the provider describe to you its possible side effects, from EI. Two or more side effects addressed by provider and Three or more addressed, both from OG). 7) Alarm signs (One or more addressed by provider, Two or more addressed, Three or more addressed, all from OG). 8) Follow-Up Instructions (Concerning the method chosen, did

the provider tell you what to do if you had any problem? and That you could switch methods if you were dissatisfied?, both from EI. Three or more follow-up instructions for method chosen addressed by provider, from OG). 9) Client Satisfaction (Would you recommend the service you received to a relative or friend? and How did you feel during the consultation?, both from EI. Client received preferred method [unless contraindicated or changed her mind], from OG). Each item is scored 1 (yes) or 0 (no).

Appendix 5

Target Setting for the Callao DISA

The 8-step procedure was implemented for the Callao DISA in 2001 as follows

1. Number of women in reproductive age = 234,539.

2. Percentage with need for family planning = 50%, or 117,270.

3. Yearly target: 52%, or 121,960.

4. Percentages corresponding to modern (69.9%, or 85,250) and traditional methods (30.1%, or 36,710).

5. Percentage of modern methods corresponding to the MOH (71%, or 60,528).

6. Percentage of traditional methods corresponding to the MOH (71% x .05 coverage = 1,303).

7. Method mix of previous year (e.g., 576 tubal ligations).

8. Calculation of couples protected and supplies required in 2001 (e.g., 602 tubal ligations).

These targets are disaggregated for individual facilities within the DISA. For example, the Base Perú-Corea health center is expected to produce 6,159 yearly number of couples protected in 2001, including 260 IUD insertions and 67 sterilizations.

Appendix 6

RADIO SPOT

RIGHTS OF USERS OF HEALTH SERVICES

SPEAKER	DIALOGUE
Neighbor	Hello, neighbor! Where do you come from?
User	From the health post. My son's godmother told me to go to learn about methods to take care of myself and do not have more children.
Neighbor	And, how did you fare?
User	Very well.
Neighbor	Good! My husband has told me to go, too, for we already have too many children. How is it?
User	One is treated well. They told me about all methods and I learned new things, that I did not know.
Neighbor	Ah, yes? What did they tell you?
User	That I can choose the method I want.
Neighbor	And, what happens if someone pressures you?
User	No, neighbor. The decision is yours. You choose freely, no one obliges you.
Neighbor	You are right. I also think that no one has the right to pressure us nor decide for ourselves.
Nurse-Obstetrician	That's it. You have the right to choose freely and without pressures the contraceptive method that best responds to your needs, your beliefs, and your preferences.
Voice	If you need counseling about family planning, go to your nearer health center. And if you have any problems, you can complain at the office of the Ombudsman.
Voice	This was a message from your Health Directorate, the Ministry of Health.